

Medical, Dental & Vision Benefits For Home Care Workers

SEIU LOCAL 775 MULTIEMPLOYER HEALTH BENEFITS TRUST

ENROLLMENT APPLICATION

Administered by Benefit Solutions, Inc.

3400 188th St., SW Suite 601, Lynnwood, WA 98037

(425) 967-0237 or (866) 771-7359

Participation Rules:

Members must work the required hours of 86 hours or more per month, and cannot have other health coverage in order to participate in this Plan with the possible exception of Medicare. If you are on Medicare you can receive secondary coverage through this Plan. If you should acquire other coverage while you are enrolled in this Plan, you must notify the Administrative Office immediately.

This insurance is for home care workers and does not cover family members or dependents. If your application is approved, the health insurance company will mail you an insurance card and more information. **You will not be covered until you receive this information.**

MEDICAL PLAN INFORMATION

Check One	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Member	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Other	
PERSONAL INFORMATION: <i>Please Print Clearly and in English</i>						
Member Name:	Last	First	MI			
Address:						
City:				State:	Zip:	Date of Hire:
Social Security Number		Date of Birth:	Marital Status:	Phone: ()		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Payee/ Vendor Number		Member E-mail Address		Language Preference		
Current or Prior Coverage Information	Date Coverage Began:		Date Coverage Ended:		Name of Insurance Company:	

If you have had other coverage in the last twelve months, please include a copy of your Certificate of Coverage.

By completing this application, I agree to the required \$17.00 monthly payroll deduction for my health coverage.

The information I have given in this application is true, correct and complete to the best of my knowledge. I understand that if I withhold information or give false or misleading information, I will lose coverage. If I have given false information, the Trust may prosecute me for perjury or bill me for ineligible services.

Member Signature (application must be signed in order to enroll in the Plan)

Date

Please return this form to Benefit Solutions at the above address or FAX to: (425) 771-1226